part of the internal generative organs were found in the sac in nineteen cases. Bowel was present in the sac in only fifteen per cent. In contrast to this, Corner gives statistics showing that in irreducible hernia of adult females the internal organs of generation were found in only eight per cent. From this it is safe to assume that irreducible inguinal hernia in a female infant is sure to contain some portion of the internal genitalia. There are valuable clinical characteristics depending upon whether the hernia is irreducible or strangulated. If irreducible, a small round body the size of a pea can be detected, which is the ovary. If strangulated, there is an irreducible non-translucent mass; the bowels move freely and there is no vomiting, unless the contents contain bowel. This occurs in fifteen per cent.

The mass increases in size, but, strange to say, the child suffers very little inconvenience. The treatment of both irreducible and strangulated hernia is operative. An extremely interesting feature, is, that the supposed ovary when microscopically examined will in some cases be found to be immature testicles, thereby making the case one of true hermaphroditism. (C. J. M.)

COMATOSE PERNICIOUS MALARIA.

Journal of American Medical Association. (Vol. 50, No. 23, June 6, 1908.)

Charles Sumner Neer reports three cases, stating that comatose is the most frequent type of pernicious malaria. Its prompt recognition is important because of effect on mortality of early treatment.

The majority of cases are due to æstivo-autumnal type of the plasmodia. Nothnagel reports two cases due to tertian parasite. Aside from pre-existing condition of the individual the coma depends on three factors:

1. Number of parasites present.
2. Amount of toxins secreted.
3. Localization of parasites in the brain.

The attacks usually occur in cases that have not been properly treated. Some predisposing causes are: anemia, cachexia, physical or mental fatigue, the puerperium, alcoholism.

The pathology is the same in most respects as any severe malarial infection, namely, breaking down of the red blood cells, oligocythemia, hemoglobinemia, melanemia, pigmentation of the white blood cells and in most cases a relative increase in the mononuclears.

Craig states that in all fatal cases of malaria the urine contains albumen, hyaline and granular casts.

Actual thrombi of parasites are found blocking the capillaries of the brain. Secondary changes in the brain are, congestion of capillaries, minute hemorrhage into the brain substance, accumulation of pigment in varying amount, and a degeneration of the nerve cells. The coma usually develops gradually during a paroxysm of fever, preceded by apathy, somnolence, restlessness and melancholia. Attempts to rouse the patient call forth no response or an unintelligible muttering, may be the movements of the limbs. Tongue thickly coated. Feces and urine pass involuntarily. Retention of the urine not infrequent. Temperature is not usually high, but irregular.

Recovery takes place slowly, if at all, the patient remaining in a state of drowsiness and apathy for several days. With another paroxysm the patient may relapse into coma. Death usually comes suddenly and unexpectedly as a result of cardiac insufficiency.

Nervous symptoms are of interest; the limbs are relaxed and lifeless, but have motor symptoms as twitching of the muscles. Nothnagel says skin reflexes are markedly diminished while tendon reflexes are ordinarily intact. Symptoms of focal disease of the brain sometimes persist after the attack, as hemiplegia, with or without aphasia, paraplegia with aphasia, and monoplegia.

Diagnosis sometimes can be made by previous history, but is made positive by microscopic examination of the blood.

This comatose condition is most apt to be confused with cerebral apoplexy, sunstroke, and uremia. By urinary examination alone it is impossible to distinguish comatose malaria from uremia.

The prognosis is grave. Cardamitis places the mortality under the most favorable conditions with prompt treatment at 20 per cent., under favorable conditions at 50 per cent.

Treatment is quinine hypodermically in the form of hydrochlorate, the bisulphate or the muriate of quinine and urea.

Osler advises 30 grains of the bisulphate with 5 grains tartaric acid every 2 or 3 hours or 10 to 20 grains of quinine and urea.

Craig thinks 8 grains of the hydrochlorate repeated until 24 have been given sufficient.

(O. N. B.)

RHEUMATISM.

The Quarterly Journal of Medicine, Vol. 1, No. 3, April, 1908. A contribution to the subject of rheumatism upon a study of 52 cases in children under five years of age, and an analysis of 100 cases of fatal suppurative pericarditis in childhood. By F. J. Poynton.

There is much difference of opinion as to frequency of rheumatism in children under five years old. Poynton prefers calling it rheumatism instead of acute rheumatism.

It is the opinion of many that there are more than one infective agent. It does not make a mysterious appearance at any particular age, but is throughout life a menace to some constitutions.

The diagnosis under five years of age is to be made to differentiate it from scurvy, anterior poliomyelitis, spinal caries, congenital syphilis, gonococcal and meningococcal arthritis, congenital heart disease, influenzal and pneumococci septicæmia.

Along this line Poynton collected 100 fatal cases of suppurative pericarditis under twelve years, mostly as results of pneumococci infec- with rheumatism, which he regards as an entity, that comes close to it bacteriologically and clinically. The frequency of rheumatism in children is sufficient to make one believe that it obeys the laws of other infections.

Aside from the fifty-two cases under five years old, he reports seventeen cases in older children whose parents gave a history of an early attack. These cases establish the fact that rheumatism, like other great infections, has no age limit. The disease under five resembles very closely the condition over five years. The mortality is high at this early age, many dying of a terminal pericarditis. One characteristic case is given of purulent pleural effusion with suppurative pericarditis, but there was no arthritis nor endocarditis: Rheumatic pericarditis is easy of diagnosis while suppurative pericarditis is very difficult. In only six of the one hundred cases was it detected with certainty. The friction sound was only present in two per cent. of the suppurative pericarditis, but is very frequent in rheumatic pericarditis.

Fifty-four of the cases were associated with emphyema of one or both sides, and thirty-one with acute pleurisy or pneumonia. Poynton also made an analysis of 150 cases of fatal rheumatism under twelve years, 149 of which showed valvular lesion.

Post-mortem records show that this suppurative pericarditis may last many weeks before proving fatal, and the illnesses associated with this condition may be grouped into three classes:

1. The acute, running a course of about four weeks.
2. The sub-acute, lasting from four to six weeks.
3. The chronic, with insidious onset, lasting from six months to one year.

He concludes by stating that rheumatism, though unusual, is by no means rare under five years, and strongly supports the specific nature of the infection. (O. N. B.)

tion. These cases were studied side by side